CoAG and Primary Health Reform

Chronic disease prevention and management, integration and community care continue to be key themes for primary health and community care as the papers in this issue of the Journal attest. Three quarters of Australians have an ongoing chronic illness (Australian Bureau of Statistics, 2006).

The Council of Australian Governments has recently emphasised the importance of health promotion and disease prevention (Council of Australian Governments, 2006), but to date proposals for action have been disappointing. There is now a plethora of research on these issues and innovative policy and practice to deal with them. There is little doubt that primary health and community care programs are important for the effective delivery of chronic disease prevention. Yet, it remains difficult to get concrete progress towards a national policy framework for primary health and community care. Instead we have incremental, piecemeal attempts at reform. Why is this so?

The road blocks to reform are solidly grounded in the complex intergovernmental relationships, roles and responsibilities for health. The Commonwealth largely has direct responsibility for the delivery of primary medical, pharmaceutical and residential aged care services. The states have primary responsibility for public health, community health, maternal and child health, mental health, home and community care, alcohol and drug, and hospital services. More broadly, the Commonwealth derives much of its leverage from its very significant role in jointly funding a range of state-managed services and private health insurance. Similarly, with the notable exception of private health insurance, the states are overwhelmingly responsible for the regulation and accreditation of health services and health professionals.

The problems of workforce shortages, limitations in existing roles and service organisation, continuity of information and care, fragmentation and duplication of governance, multiple payment and accountability systems and inefficient financing arrangements have been well documented. There have been repeated calls for a national primary health care strategy over the past 10 years.

However, comprehensive reform is only possible if the Commonwealth and the states agree; they are only likely to agree when their interests coincide. Narrowly, each is caught between short-term risks to budget outcomes and adverse public perceptions of performance on indicators such as waiting lists, bulk-billing rates and catastrophic quality failures. Opposition parties and professional, non-government and consumer interest groups are adept at exploiting these to drive specific agendas. More broadly and in the longer term, both levels of government are concerned about the cost-benefit of their programs on health outcomes, productivity and economic efficiency.

Governments are therefore caught between narrow, short-term imperatives and the need to address broader, long-term objectives. Generally, immediate short-run issues will dominate unless the threat from ignoring longer-term issues is very high. Ministers are loath to enter into areas where they have limited capacity to affect outcomes and a high probability of incurring political risk.

Nevertheless, there are now a number of signs that ignoring the long-run issues will produce significant risks. It is clear, as the (Productivity Commission, 2005) has argued, there will be a significant increase in chronic illness and demand for health and aged care services in the next two decades. The absolute number of people aged over 70 will double in this period. Health expenditure as a proportion of GDP is predicted to reach 15 or 16% and aged care expenditure as a proportion of GDP is likely to double. It is unlikely that existing arrangements can be incrementally adjusted to meet the looming demands ahead. Nor is it likely that the "baby boomers" will tolerate the current system well.

Notwithstanding a decade of review and discussion about general practice, and the introduction of measures such as divisions of general practice, vocational training, a range of new Medicare items, blended payments, practice accreditation and rural incentive schemes, little has actually changed in the functional organisation and performance of primary health and community services. Primary care remains dominated by small-scale practices focused on episodic GP-delivered services. Capacity to deliver integrated community-based care through primary care organisations is extremely limited and in many cases hospitals have stepped into the breach. Similarly, there are few primary care organisations with the capacity

to manage comprehensive coordination and management of care for people with complex chronic conditions across acute, sub-acute and community settings. Nor are the majority of primary health care agencies (including GP practices) well organised to effectively provide prevention and early intervention for chronic disease. We still do not have a national primary health care policy.

There are significant and obvious gains to be made in the organisation of primary health and community services, but this will require structural and institutional change in the financing, governance and organisation of services. Recently there have been some useful suggestions like those of the Australian Divisions of General Practice in this respect (Australian Divisions of General Practice, 2006). It will be interesting to see whether short-run interests continue to dominate Council of Australian Government decision-making, or if longer-term concerns come to the fore.

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Refrences

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